SDMI Determination Request

Date: _____/_____/_______

Name: ____________________________________ SS#: ____

Address: ____Phone: __________________________

Current Location: ____

Contact Person: ____Phone:___________________________

Diagnosis: ____

Mental Health Services Involved: No ____ YES____ Summary of known treatment history and services requested:

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MPQHF Reviewer: ___________________________________Phone: 1-800-219-7035

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SDMI Determination Results: (Please fill out and fax back to MPQHF 1-800-413-3890)

_______ Does not meet SDMI

_______ Meets SDMI Diagnosis____

Please indicate any ongoing functioning difficulties because of mental illness that have been present for a period of at least 6 months, or will be present for an obviously predictable period over 6 months.

_____ Medical professional with prescriptive authority has determined that medication is necessary to control symptoms of mental illness.
Comment: ____

_____ The person is unable to work in a full-time competitive situation because of mental illness.
Comment: ____

_____ The person has been determined to be disabled due to mental illness by the Social Security Administration.
Date of determination: ____

_____ The person maintains a living arrangement only with ongoing supervision, is homeless, or is at risk of homelessness due to mental illness.
Comment: ____

_____ The person has had or will predictably have repeated episodes of decompensation (increased symptoms of psychosis, self-injury, suicidal or homicidal intent, or psychiatric hospitalization.)
Comment: ____

Other comments:

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Mental Health Evaluator: ____Phone: __________________
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